

DOCUMENTATION OF PREVIOUS ADHD TREATMENT

Providers, please fill out the form below so that this student may continue treatment at AU SHC. **Please include a copy of chart notes and any information regarding recent prescriptions.** Please submit the completed form and accompanying notes back to our office.

- < Email: shc@american.edu
- < Fax: **(202) 885-1222**
- < Mailing address:

**American University
Student Health Center
4400 Massachusetts Avenue, NW
McCabe Hall
Washington, DC**

Students Name: _____ Date of Birth _____

Providers Name: _____ Specialty _____

Name of Practice: _____

Address: _____

Telephone: _____ Fax: _____

Please list any medication this patient is currently taking:

Please state if this patient was diagnosed with or treated for any other behavioral health condition:

Please list any other medical conditions for this patient:

Do you have any concerns about this patient misusing stimulants or other substances? NO YES

If yes, please explain:
